



Montgomery County Department of Health and Human Services  
Licensure and Regulatory Services  
255 Rockville Pike, Suite 100, 1<sup>st</sup> Floor, Rockville, Maryland 20850  
Phone: 240-777-3986 Fax: 240-777-3088  
[www.montgomerycountymd.gov/licensure](http://www.montgomerycountymd.gov/licensure)

**SWIMMING POOL MANAGEMENT COMPANY REGISTRATION**  
(LICENSES ARE NOT TRANSFERABLE FROM LOCATION TO LOCATION OR PERSON TO PERSON)

TODAY'S DATE: \_\_\_\_\_

Management Company Name: \_\_\_\_\_

Management Company Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_ Federal Tax ID: \_\_\_\_\_

Email Address (**REQUIRED**): \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Pool Name (Facility): \_\_\_\_\_

Pool Address: \_\_\_\_\_

Pool Management Company Representative Responsible for this facility:

Name: \_\_\_\_\_ Telephone No.: \_\_\_\_\_ Fax: No: \_\_\_\_\_

Email Address: (**REQUIRED**) \_\_\_\_\_

Date individual was notified or will be notified regarding this assignment: \_\_\_\_\_

**Pool Management Company responsibilities: (Check all that apply).**

- ☐ Assuring compliance with all operating standards set forth in Chapter 51 of the Montgomery County Code and all rules and regulations promulgated hereunder.
- ☐ Providing for the physical maintenance, supplies and personnel as required by Chapter 51 and all rules and regulations promulgated hereunder.
- ☐ Obtaining all necessary permits and licenses.

***NOTE: POOL MANAGEMNET COMPANY MUST NOTIFY THE LICENSURE AND REGULATORY SERVICES DIVISION WITHIN 48 HOURS OF ANY CHANGE IN RESPONSIBLE PERSONNEL.***

**Workers' Compensation Insurance Company Name:** \_\_\_\_\_ **Policy/Binder No.:** \_\_\_\_\_

Check here ☐ if this facility is operated by a sole proprietor with no employees, or by members of a partnership or LLC, and a Certificate of Compliance has been obtained.

*If you do not have Worker's Compensation Insurance, you must submit a copy of the Certificate of Compliance issued by the Worker's Compensation Commission (410-864-5100 or 800-492-0479).*

I hereby certify that the above information is accurate and complete:

Signature of Applicant: \_\_\_\_\_ Printed Name and Title of Applicant: \_\_\_\_\_

**Payment Method: \$55 (Per Facility) Area:**

☐ Check ☐ Money Order ☐ Visa ☐ MasterCard **CASH IS NOT ACCEPTED** Amount: \$ \_\_\_\_\_

Credit card payments fax to: 240-777-4531 (confidential fax line).

Credit Cardholder's Name: \_\_\_\_\_

Credit Card No: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ 3 Digit Security Code: \_\_\_\_\_

**I agree to pay the indicated total amount according to card issuer agreement:**

Cardholder's Signature: \_\_\_\_\_

Submit completed application and application fee to address at the top of the application. Checks or money orders are payable to "Montgomery County, Maryland".

**OFFICE USE ONLY**

Receipt No: \_\_\_\_\_ Amount Paid: \_\_\_\_\_ Date Received: \_\_\_\_\_

Approval/Check #: \_\_\_\_\_ Expires: \_\_\_\_\_ Staff Initials: \_\_\_\_\_